

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34288
STATE FILE NUMBER
8412

FILED OCT 4 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6600a Michigan</u>				Length of stay in lb		STREET ADDRESS <u>6600a Michigan</u> (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Thomas Weaver</u>				4. DATE OF DEATH Month Day Year <u>Sept. 7, 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 11, 1941</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>student</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles F. Weaver</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte unk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Charles F. Weaver 6600a Michigan</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Suffocation from inhalation of</u> <u>Propane Gas.</u> DUE TO (c) <u>8900</u> <u>15</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Then found in house, Sept. 7, 1957. Whether accidental or suicidal could not be determined</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of form if applicable. <u>See above</u>					
20c. TIME OF INJURY Hour Month, Day, Year <u>3</u> <u>9 7 57</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office, bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>St Louis Mo</u>		COUNTY		STATE	
21. I attended the deceased from <u>130 P.</u> , to <u>her</u> and last saw <u>him</u> alive on <u>Death occurred at</u> <u>1300 Clark</u> <u>9/9/57</u> <u>m on the date stated above; and to the best of my knowledge, from the causes stated.</u>							
22a. SIGNATURE <u>Robert M. Smith</u>		22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>9/9/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>9-11-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		23d. LOCATION (City, town, or county) (State) <u>Lemay 23, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Southern Funeral Home</u> <u>6322 S. Grand, St. Louis, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>SEP 9 '57</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> <u>m.g. r.</u>	

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Corners office

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *David Van Ness*

Licensed Embalmer No. *42*

P. O. Address *S. H. Louie*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.